MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Mak-Shur dba Relief 1225 North Loop West, Suite 925 Houston, TX 77008	MDR Tracking No.: M4-03-4644-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Zurich American Insurance Co. Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.: 3A811894

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09/13/02	09/13/02	E-1399	$43.75	$43.75

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 05/30/03 states in part, "…Mak-Shur is a durable medical equipment company that provides electrotherapy products and supplies to patients in Texas. Mak-Shur has followed the TWCC guidelines regarding the billing and documentation required for the supplies for purchased medical equipment. Based on the TWCC Fee guideline, Mak-Sur is entitled to payment of the remaining balance due for each claim…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated May 30, 2003 states in part, "…The provider is requesting additional reimbursement, however the provider has not established entitlement tothat additional reimbursement… The provider is not entitled to additional reimbursement above the MAR… the provider is requesting is requesting additional reimbursement because the claimant allegedly requested additional supplies…The provider has submitted no documentation to substantiate the additional requested by the claimant…There is no evidence of the claimant's 'additional' request..."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- HCPCS Code E-1399 for date of service 09/13/02 denied as "M – No MAR". The requestor billed $128.75 for NMES muscle stimulator and was reimbursed $85.00 by the respondent. The 1996 Medical Fee Guideline, DME Ground Rule (X)(C) governs TENS unit supplies only; therefore per Rule 133.1(a)(8) the requestor has submitted convincing evidence in the form of redacted EOBs to support additional reimbursement. Additional reimbursement in the amount of $43.75 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
9/13/2002	E-1399	$43.75	$43.75				
				Total Left Column:			$43.75
				Total Amount Due:			$43.75

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $43.75. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	10-28-04 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____